

**Attachment B**

Arkansas Department of Health  
**Authorization for Automatic Electronic Funds Deposit**



Provider Legal Business Name: \_\_\_\_\_ Provider #: \_\_\_\_\_

Doing Business As Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Type of Authorization: Same  Change  New

**For verification purposes, please complete the following:**

Routing Transit # : \_\_\_\_\_ Bank Account #: \_\_\_\_\_

**PLEASE ATTACH A COPY OF A BANK LETTER TO VERIFY THESE NUMBERS.** The name on the voided check/deposit slip should match the name on the provider business name of DBA state above

Name of Depository (Bank): \_\_\_\_\_

Depository Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I hereby authorize the DHHS, *BreastCare* to initiate credit entries to the account indicated above and the depository named above to *credit* the same to such account. I understand that I am responsible for the validity of information on this form.

I understand in endorsing this funds transfer that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

DHHS BreastCare will send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to BreastCare an updated Automatic Authorization Agreement.

Authorized Official Name (*Print*): \_\_\_\_\_

Authorized Official Title: \_\_\_\_\_

Authorized Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to:  
*ADH, BreastCare*  
4815 West Markham, Slot 11  
Little Rock, AR 72205